APPLICATION FOR MEMBERSHIP IN THE FLORIDA SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS

I. **Full Name** _____ Degree(s) _____

II. **Office Street Address** **City/State/Zip Code** **Phone Number** **Fax Number**

#1 _____

#2 _____

#3 _____

Email address: _____ **Nickname**_____

III. **Residence Address**: _____ Home Phone _____

City: _____ State: _____ Zip Code: _____

IV. **Date and Place of Birth**: _____

V. **Education**:

Undergraduate: _____ Dates: _____

Dental School _____ Dates:_____

Fellowship: _____ Dates: _____

Oral Surgery:

1st Year: _____ Dates: _____

Director (Chief): _____ Phone: _____

2nd Year: _____ Dates: _____

Director (Chief): _____ Phone: _____

3rd Year: _____ Dates: _____

Director (Chief): _____ Phone: _____

4th Year: _____ Dates: _____

Director (Chief): _____ Phone: _____

Medical School: _____ Dates: _____

Internship: _____

VI. **State Licensure with dates**: (Dental) _____

(Medical) _____

VII. **Military Experience**: (Rank and Dates): _____

_____

VIII. **Is your Practice limited exclusively to Oral Surgery?** Yes _____ No _____

If yes, number of years in practice: _____ Dates: _____

If no, please explain: _____

FSOMS Membership Application

IX. Are you a member of the Southeastern Society of Oral and Maxillofacial Surgeons?

Yes _____ No _____ Dates: _____

X. Are you a member of the American Association of Oral and Maxillofacial Surgeons?

Yes _____ No _____ Date: _____

If yes, please mark status: Applying: _____ Member/Fellow ____ Provisional ____ Candidate ____

XI. Are you a Diplomate of the American Board of Oral and Maxillofacial Surgeons?

Yes: _____ No: _____ Date: _____

XII. **Are you affiliated with a teaching institution?** Yes _____ No _____

If yes, name of institution: _____

Faculty position: _____ Dates: _____

XIII. **Active membership in professional societies**: _____

_____

_____

XIV. Present Hospital Staff Affiliation

Name Address _____

_____

_____

_____

XV. Letters of Recommendation from two FSOMS Member oral surgeons are required.

1. Name _____ Years Known: _____
2. Name _____ Years Known: _____

PERSONAL HISTORY

If married, spouse name: _____

Names and ages of children: _____

Membership in Civic Clubs, Fraternities, Etc. _____

_____

_____

I authorize investigation into statements made in this application. I understand that I must abide by the Code of Ethics of the Society, and may be expelled for violation of it. The certificate of membership issued by the FSOMS remains the property of the Society and must be returned to the FSOMS upon withdrawal form or termination of my membership in the Society.

_____ Date: _____

Signature